

1
2
3 UNITED STATES DISTRICT COURT
4 EASTERN DISTRICT OF WASHINGTON

FILED IN THE
U.S. DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON

Aug 07, 2018

SEAN F. MCAVOY, CLERK

5 PATRICK G. BROTHERTON,
6

7 Plaintiff,

8 v.
9

10 UNITED STATES OF AMERICA,
11

Defendant.

NO. 2:17-CV-00098-JLQ

ORDER RE: DEFENDANT'S MOTION
FOR SUMMARY JUDGMENT

12 BEFORE THE COURT is Defendant's Motion for Summary Judgment (ECF No. 28).
13 Response and Reply briefs have been filed. (ECF No. 35 & 41). The court heard oral
14 argument on the Motion on July 26, 2018. Plaintiff was represented by Jess Casey and
15 Marshall Casey. Assistant United States Attorneys Joseph Derrig and Rudolf Verschoor
16 appeared on behalf of Defendant. This Order memorializes and supplements the court's oral
17 rulings.

18 **I. Introduction**

19 Plaintiff, Patrick Brotherton, filed this action against Defendant, the United States of
20 America, on March 15, 2017. Plaintiff brings two claims relating to medical care he received
21 in January 2014. Plaintiff asserts failure to secure informed consent in violation of RCW
22 7.70.050 and medical negligence under RCW 7.70.040. These claims are asserted on the
23 basis of care provided by "Dr. Sim or the VA medical personnel."

24 The Defendant (hereafter "Government") argues Dr. Sim, the VA physician, had no
25 duty to obtain informed consent because that duty belongs to the surgeon, Dr. Barrow, not to
26 the referring physician. On the negligence claim, the Government argues Dr. Sim did not

1 breach a duty as he conveyed lab results to Dr. Barrow. Further the Government argues there
2 is no causation between Dr. Sim and Plaintiff's injury as Dr. Barrow performed the surgery
3 which ultimately led to amputation¹.

4 Plaintiff argues his expert Dr. Leo opines Dr. Sim "is not allowed to just abandon
5 [Plaintiff] and do nothing when [Plaintiff] faces a significant and modifiable risk due to
6 diabetes." (ECF No. 35, p. 3). On informed consent, Plaintiff argues Dr. Sim had a duty
7 because he had specific knowledge of Plaintiff's history of uncontrolled diabetes. (*Id.* at p.
8 19-20).

9 **II. Factual Background**

10 In summary judgment proceedings, the facts are viewed in a light most favorable to the
11 non-movant, in this case the Plaintiff. The following facts are set forth in a light favorable
12 to the Plaintiff and key factual disputes are noted. Defendant filed a 75-paragraph Statement
13 of Facts (ECF No. 29). Plaintiff filed a 55-paragraph Statement of Facts in Response (ECF
14 No. 36). Local Rule 56.1(b) provides a responding party "must explicitly identify any fact(s)
15 asserted by the moving party which the opposing party disputes or clarifies. (E.g.:
16 "Defendant's fact #1: Contrary to Plaintiff's fact #1 ...)". Plaintiff's Statement of Facts in
17 Response only specifically identifies two of the Government's facts which he disputes --
18 Government's Facts #5 and # 13. Therefore, the facts at issue are largely undisputed.

19 Plaintiff was first diagnosed with diabetes in 1996. For some period of time he took
20 insulin, but after having gastric bypass surgery in 2004, he ceased taking insulin. (ECF No.
21 36, ¶¶ 4, 6). Dr. Daniel Sim, M.D., was Plaintiff's primary care physician at the Mann-
22 Grandstaff VA Medical Center (hereafter "VA"). (ECF No. 29, ¶ 1). Plaintiff first saw Dr.
23 Sim for medical care at the VA in August 2004, and the medical records from the visit note
24

25 ¹The court has been informed Plaintiff has pending claims against Dr. Barrow in state
26 court. (ECF No. 5-4).

1 an A1C of 8.3. (ECF No. 29, ¶ 6). A hemoglobin A1C reading represents a three-month
2 historical view of a patient's blood glucose level. (ECF No. 36, ¶ 1).

3 Over the years, Plaintiff's A1C level was routinely higher than the desired score of 7.0
4 or lower. Dr. Sim testified Plaintiff's diabetes was "uncontrolled". Over the years, Dr. Sim
5 recommended and prescribed various medications, but Plaintiff preferred to attempt to control
6 his diabetes through lifestyle changes. Plaintiff tried the medication, Metformin, but had side
7 effects, and was resistant to trying another, Glipizide.

8 On January 29, 2013, Dr. Morton, a podiatrist at the VA, diagnosed Plaintiff with a
9 diabetic foot ulcer on his left foot. (ECF No. 29, ¶ 9). On May 30, 2013, Dr. Morton referred
10 Plaintiff to a non-VA orthopedic surgeon for evaluation and treatment of Plaintiff's malunion
11 right ankle fusion. (*Id.* at ¶ 11). The VA authorized a visit to the surgeon for evaluation and
12 treatment of the right ankle. (*Id.* at ¶ 12). Plaintiff was referred to Dr. Craig Barrow, who is
13 not a VA employee or U.S. government employee. (*Id.* at ¶ 4). Dr. Barrow first saw Plaintiff
14 on August 19, 2013. Dr. Barrow was aware of Plaintiff's diabetes and the ulcer on his left
15 foot. Plaintiff, on his intake form, wrote his diabetes was "controlled". (*Id.* at ¶ 18).

16 At the August 19, 2013, appointment, Dr. Barrow discussed the treatment plan for a
17 corrective osteotomy surgical procedure on Plaintiff's right ankle. Dr. Barrow discussed the
18 risks of surgery, including amputation. (ECF No. 29, ¶ 20-21). Plaintiff signed a consent
19 form for the planned surgery. (*Id.* at ¶ 22). On September 5, 2013, Dr. Sim sent Plaintiff a
20 letter informing him his A1C level was 8.2, with a recommended target of less than 7.0. He
21 recommended Plaintiff take the medication, Glipizide. (*Id.* at ¶ 25). Dr. Sim then saw
22 Plaintiff for various issues on September 10, 2013; October 10, 2013; and October 23, 2013.
23 (*Id.* at ¶ 26-29).

24 On October 28, 2013, Plaintiff saw Dr. Barrow again, and Dr. Barrow examined the
25 ulcer on the left toe and noted it was improving and slowly healing. Dr. Barrow saw Plaintiff
26 again on November 25, 2013, and again noted the ulcer on the left foot was still slowly

1 healing. Dr. Barrow was waiting to perform the surgery on the right ankle until after the ulcer
2 on the left foot had fully healed. At an office visit on January 7, 2014, Dr. Barrow found the
3 left foot had sufficiently healed and decided to proceed with surgery. (*Id.* at ¶ 34).

4 At the January 7, 2014 office visit, Dr. Barrow explained the risk of surgery and
5 Plaintiff signed a consent form. Dr. Barrow requested some pre-surgical labs, but did not
6 request a medical clearance evaluation from Dr. Sim or the VA. On January 10, 2014,
7 Plaintiff telephoned Dr. Sim's office and left a message that he was having the surgery on
8 January 17, 2014, and asked if he could have his blood work done at the VA. The blood work
9 was done and showed an A1C of 9.6². The lab results were sent to Dr. Barrow on January 16,
10 2014, the day before the surgery. (ECF No. 29, ¶ 39). Dr. Barrow testified he did not review
11 the A1C report prior to the surgery, but did conduct a blood glucose test the morning of the
12 surgery. (ECF No. 29-2, Depo. of Dr. Barrow, p. 30-31).

13 Dr. Barrow's opinion is the A1C test was not a contraindication to surgery, and from
14 the blood sugar test performed the morning of the surgery, Dr. Barrow determined Plaintiff's
15 blood sugar level was sufficient to proceed with the surgery. (*Id.* at ¶ 40-41). Plaintiff signed
16 another consent form on the day of the surgery advising of the risks of surgery. The surgery
17 was performed on January 17, 2014, and on January 20, 2014, Plaintiff was discharged. (*Id.*
18 at ¶ 49). Discharge instructions told Plaintiff to monitor his blood sugar closely, take diabetic
19 medications as directed, or otherwise he would be at "an increased risk of infection, wound
20 problems and bone healing delays." (*Id.* at ¶ 50).

23 ²According to the records, Plaintiff took the pre-operative lab orders(including CBC,
24 CMP) to the VA on Monday January 13, 2014, but only the A1C was done at that time, and
25 the other tests were performed at Holy Family Hospital the morning of surgery. (ECF
26 No. 15-3, p. 10).

1 Plaintiff states his blood sugar level was 283 at discharge and claims Dr. Barrow did
2 not instruct him on blood sugar monitoring. (ECF No. 36, ¶ 46). Three days after discharge,
3 on January 23, 2014, Plaintiff contacted the VA and requested post-surgical care and
4 assistance, including possibility of placement in a skilled nursing facility. (*Id.* at ¶ 47).
5 Placement in a nursing facility was not immediately available, and on January 29, 2014,
6 Plaintiff reported he was doing fine at home and declined nursing facility placement.

7 Plaintiff was admitted to Holy Family Hospital on February 8, 2014, for I & D
8 (irrigation and debridement) for “wound dehiscence” and ulcer and cellulitis of the surgical
9 site. (ECF No. 29-2; Ex. F-143). By February 20, 2014, after further attempts at debridement
10 and wound treatment, Dr. Barrow discussed with Plaintiff the need for a below-knee
11 amputation. (*Id.* at Ex. F-144). The amputation procedure was performed on March 19,
12 2014.

13 **III. Discussion**

14 **A. Summary Judgment Standard**

15 The purpose of summary judgment is to avoid unnecessary trials when there is no
16 dispute as to the material facts before the court. *Northwest Motorcycle Ass'n v. U.S. Dept.*
17 *of Agriculture*, 18 F.3d 1468, 1471 (9th Cir. 1994). The moving party is entitled to summary
18 judgment when, viewing the evidence and the inferences arising therefrom in the light
19 most favorable to the nonmoving party, there are no genuine issues of material fact in dispute.
20 Fed. R. Civ. P. 56; *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252 (1986). While the
21 moving party does not have to disprove matters on which the opponent will bear the burden
22 of proof at trial, they nonetheless bear the burden of producing evidence that negates an
23 essential element of the opposing party’s claim and the ultimate burden of persuading the
24 court that no genuine issue of material fact exists. *Nissan Fire & Marine Ins. Co. v. Fritz*
25 *Companies*, 210 F.3d 1099, 1102 (9th Cir. 2000). When the nonmoving party has the burden
26 of proof at trial, the moving party need only point out that there is an absence of evidence to

1 support the nonmoving party's case. *Devereaux v. Abbey*, 263 F.3d 1070, 1076 (9th Cir.
2 2001).

3 Once the moving party has carried its burden, the opponent must do more than simply
4 show there is some metaphysical doubt as to the material facts. *Matsushita Elec. Indus. Co.*
5 *v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986). Rather, the opposing party must come
6 forward with specific facts showing that there is a genuine issue for trial. *Id.*

7 Although a summary judgment motion is to be granted with caution, it is not a
8 disfavored remedy: "Summary judgment procedure is properly regarded not as a disfavored
9 procedural shortcut, but rather as an integral part of the Federal Rules as a whole, which are
10 designed to secure the just, speedy and inexpensive determination of every action." *Celotex*
11 *Corp. v. Catrett*, 477 U.S. 317, 327 (1986)(citations and quotations omitted).

12 **B. The 'Informed Consent' Claim**

13 Plaintiff's Complaint asserts two claims. The first is a failure to secure informed
14 consent, and Plaintiff cites to RCW § 7.70.050. Plaintiff alleges: "Dr. Sim or the VA medical
15 personnel failed to inform Mr. Brotherton of the material risk that Mr. Brotherton would lose
16 his foot as a result of the surgery." (ECF No. 1, ¶ 4.3). A claim based on failure to secure
17 informed consent has four elements under Washington law. *Backlund v. Univ. of Washington*,
18 137 Wash.2d 651 (1999); RCW § 7.70.050. The claimant must establish:

19 1) The health care provider failed to inform the patient of a material
20 fact or facts relating to treatment;

21 2) The patient consented to the treatment without being aware of or
22 fully informed of such material fact or facts;

23 3) A reasonably prudent patient under similar circumstances would not
24 have consented to the treatment if informed of such material fact or facts; and

25 4) The treatment in question proximately caused injury to the patient.

26 *Id.*

The critical issue here is whether Dr. Sim, who did not perform the surgery, had a legal
duty to secure informed consent regarding Brotherton's ankle surgery performed by Dr.

1 Barrow. “The existence of a legal duty is a question of law and depends on mixed
2 considerations of logic, common sense, justice, policy, and precedent.” *Christensen v. Royal*
3 *School Dist.*, 156 Wash.2d 62, 67 (2005). “The concept of duty is a reflection of all those
4 considerations of public policy which lead the law to conclude that a plaintiff’s interests are
5 entitled to legal protection against the defendant’s conduct.” *Volk v. DeMeerleer*, 187
6 Wash.2d 241, 266 (2016).

7 Dr. Sim did not have a legal duty to obtain informed consent for the surgery,
8 or to advise Plaintiff of the risks of surgery – that legal obligation belonged to the
9 surgeon, Dr. Barrow. The Washington case which most directly addresses the legal duty of
10 a referring physician under Washington law is *Bottemiller v. Gentle Dental*, 2002 WL
11 31895159 (Wash. Ct. App. 2002)(unpublished). There the court examined the duty of a
12 referring physician to provide informed consent and stated, “the majority of jurisdictions that
13 have addressed whether referring physicians have a duty to obtain a patient’s informed
14 consent have concluded that they do not.” *Id.* at *10. The court observed a minority of
15 courts have imposed a duty when “the referring physician has retained a degree of
16 participation and control in the treatment.” *Id.* at *11. The *Bottemiller* court concluded that
17 because the referring physician did not participate in or control the surgery, there was no duty
18 to inform the patient that experts disagreed as to the benefit of the surgery or advise as to
19 alternatives to surgery.

20 The parties cited, and referred to at argument, *Alexander v. Gonser*, 42 Wash.App. 234
21 (1985) and *Howell v. Spokane & Inland Empire Blood Bank*, 114 Wash.2d 42 (1990),
22 however neither case is directly on point. Both cases involve the duty of informed consent
23 as between a physician and hospital staff. They do not address the duty between a primary
24 care/referring physician and a specialist/surgeon. In *Alexander*, the issue was “whether a
25 hospital has an independent duty to inform a patient of test results administered at the request
26 of the treating physician.” 42 Wash.App. at 235. The court answered in the negative. To the

1 extent it is applicable, *Alexander* supports the conclusion Dr. Barrow had the informed
2 consent duty, and not the VA or Dr. Sim.

3 In *Howell*, the court again rejected an argument that the hospital, Deaconess Hospital,
4 had an informed consent duty, and instead found the duty rested with the physician. The
5 court stated: “To provide for equal informed consent obligations as to every person and entity
6 falling within the definition [of health care provider] would not be justified.” *Id.* at 55. The
7 Washington Supreme Court further stated, “it is the duty of the physician to inform patients
8 of the risks, general or specific, involved in surgical procedures.” *Id.* at 56. Here, the
9 physician performing the procedure was the surgeon, Dr. Barrow.

10 It is undisputed Dr. Sim did not participate in or control the surgery. Plaintiff’s expert,
11 Dr. Leo, testified that in his review of the medical records he saw nothing indicating Dr. Sim
12 planned the surgery, participated in the surgery, or advised Plaintiff to have the surgery.
13 (Depo. of Dr. Leo, at ECF No. 45-1, p. 34-35). It was Dr. Morton, a VA podiatrist, who
14 referred Plaintiff to Dr. Barrow. (ECF No. 29, ¶ 11). Further, Plaintiff’s expert, Dr. Leo,
15 testified he did not expect a referring primary care physician to obtain informed consent from
16 the patient for the procedure they are being referred for. Specifically, he testified when asked:
17 “No. I do not view it as my duty or the duty of a primary care physician to obtain consent for
18 a specific procedure that assumes a fund of knowledge regarding the benefits, risks, and
19 alternatives to that particular procedure that most primary care doctors wouldn’t have.” (*Id.*
20 at p. 19-20).

21 This makes common sense. The physician performing a procedure should advise on
22 the risks of the procedure. When a primary care physician refers a matter to a specialist, it
23 is not logical to impose a legal duty on the primary care physician to explain the risk of a
24 procedure which the specialist may perform. Generally the reason for the referral to a
25 specialist is because the specialist has more training, knowledge, or experience in the
26 particular area of medicine.

1 Dr. Sim had no legal duty to obtain informed consent from Mr. Brotherton for the
2 surgery performed by Dr. Barrow. Further, even if this court were to find Dr. Sim had a duty
3 to advise of the risks of surgery, which it does not, it is undisputed Dr. Barrow did advise of
4 surgical risks³. Dr. Barrow first discussed the risks of surgery at an office visit on August 19,
5 2013, and Plaintiff signed a consent form at that time. (ECF No. 29, ¶ 21-22). Dr. Barrow
6 then discussed the risks of surgery at an office visit on January 7, 2014, ten days before the
7 surgery. (*Id.* at ¶ 34-35). Dr. Barrow advised again of the risks of surgery on January 17,
8 2014, the day of surgery, and Plaintiff signed a consent form. (*Id.* at 43-44). See *Bynum v.*
9 *Magno*, 125 F.Supp.2d 1249, 1255 (D. Hawaii 2000)(“where the surgeon obtains informed
10 consent, the referring physician’s duty to obtain it may be discharged because the chain of
11 causation is broken.”).

12 Defendant’s Motion for Summary Judgment on the first claim in the Complaint--failure
13 to secure informed consent, is **GRANTED**.

14 **C. Medical Negligence Claim**

15 Plaintiff’s second claim of negligence, pursuant to RCW § 7.70.040, alleges Dr. Sim
16 “failed to exercise the degree of skill, care, and learning expected of a reasonably prudent
17 surgeon.” (ECF No. 1, ¶ 5.2). The allegations of the Complaint are Dr. Sim knew of
18 Plaintiff’s impending ankle surgery, knew of his diabetic condition, ordered an A1C blood
19 test in preparation for surgery, received the blood test results, reported them to Plaintiff, but
20 did not advise against having the surgery. (*Id.* at ¶ 2.2-2.6).

21 RCW § 7.70.040 provides:
22
23

24 ³Any challenge Plaintiff may have to the adequacy or thoroughness of Dr. Barrow's
25 advice and consent forms is not before this court. It appears Plaintiff is pursuing an informed
26 consent claim against Dr. Barrow in state court. (ECF No. 5-4).

1
2 The following shall be necessary elements of proof that injury resulted
3 from the failure of the health care provider to follow the accepted standard of
4 care:

5 (1) The health care provider failed to exercise that degree of care, skill,
6 and learning expected of a reasonably prudent health care provider at that
7 time in the profession or class to which he or she belongs, in the state of
8 Washington, acting in the same or similar circumstances;

(2) Such failure was a proximate cause of the injury complained of.

9 A negligence claim requires a showing of duty, breach, causation, and damages.
10 *Ranger Ins. Co. v. Pierce Co.*, 164 Wn.2d 545, 552 (2008). “The existence of a legal duty is
11 a question of law and depends on mixed considerations of logic, common sense, justice,
12 policy, and precedent.” *Christensen v. Royal School Dist.*, 156 Wash.2d 62, 67 (2005).
13 Generally expert testimony is required to establish the standard of care. *McLaughlin v. Cooke*,
14 112 Wash.2d 829, 836 (1989). Expert testimony is typically also required on the issue of
15 proximate cause in medical malpractice cases. *Id.* at 837. “The concept of duty is a reflection
16 of all those considerations of public policy which lead the law to conclude that a plaintiff’s
17 interests are entitled to legal protection against the defendant’s conduct.” *Volk v. DeMeerleer*,
18 187 Wash.2d 241, 266 (2016).

19 As expert testimony is required to establish the standard of care and causation in
20 medical negligence cases, the court now addresses the Government’s **Motion to Exclude**
21 **Opinions of Dr. Leo and Dr. Coleman (ECF No. 43)**. The Government filed, on the same
22 day as its Reply in support of summary judgment, a Motion to Exclude three of the opinions
23 stated by Dr. Leo, and to entirely exclude Dr. Coleman as an improper rebuttal expert.
24 Response and Reply briefs were filed (ECF No. 44 & 49).

25 The Government argues three of Dr. Leo’s opinions lack an adequate foundation and
26 are unreliable: 1) that the standard of care required Dr. Sim, a primary care physician, to
perform a preoperative evaluation for surgery, even though one was not requested by the

1 surgeon; 2) that a preoperative A1C of 9.6 required cancellation of Plaintiff's surgery; and
2 3) that Plaintiff's preoperative A1C caused his infection. (ECF No. 43, p. 2). The
3 Government contends Dr. Coleman is not a rebuttal expert and should be excluded. The
4 Government argues Dr. Coleman did not even review the initial reports of Defendant's
5 experts, but rather only reviewed Dr. Leo's report and deposition. Thus, the Government
6 argues Dr. Coleman was been listed only to endorse Dr. Leo's opinion and is cumulative and
7 improper rebuttal testimony.

8 Plaintiff responds Dr. Leo is qualified and his testimony is reliable and should be
9 allowed. Plaintiff argues Dr. Coleman's testimony was rebuttal to the extent it was offered
10 to counteract the implication that Dr. Leo, who practices in California, was not qualified to
11 testify as to the Washington standard of care.

12 The day after the Government's Motion to Exclude was filed, the Washington Supreme
13 Court issued its opinion in *Reyes v. Yakima Health District*, 419 P.3d 819 (Slip Op. June 21,
14 2018), where the court stated: "This is a case about the sufficiency of expert witness
15 testimony in a medical malpractice suit." The Court stated: "Allegations amounting to an
16 assertion that the standard of care was to correctly diagnose or treat the patient are
17 insufficient. Instead, the affiant must state specific facts showing what the applicable
18 standard of care was and how the defendant violated it." (*Id.* at 9). The Government argues
19 in part Dr. Leo's opinion lacks specificity and does not "establish the nature and contours"
20 of the standard of care. (ECF No. 43, p. 1).

21 The Government essentially argues the three opinions of Dr. Leo, outlined *supra*, do
22 not meet the *Daubert* standard. In *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579
23 (1993), the Supreme Court set forth the standard for admitting expert scientific testimony.
24 A federal court is guided by Federal Rule of Evidence 702, and the court serves a
25 gatekeeping function. The court is to attempt to ensure "an expert's testimony rests both on
26 a reliable foundation and is relevant to the task at hand." *Id.* at 597. In assessing reliability,

1 the court may look to whether a scientific theory or technique has been tested, whether it is
2 subject to peer review, whether there is a known error rate for the study or technique, and
3 whether there is “general acceptance” of the theory or technique. *Id.* at 593-95. The inquiry
4 under FRE 702 is a “flexible one” which seeks to assess the “scientific validity and thus the
5 evidentiary relevance and reliability of the principles that underlie a proposed submission.”
6 *Id.* at 594-95.

7 Dr. Leo is a licensed medical doctor. He is board-certified and has practiced internal
8 medicine for over 30 years. At his deposition, he testified that he has given testimony as an
9 expert witness over 300 times. He has been consulting as an expert witness for approximately
10 20 years and testified it is roughly 50/50 as to whether he is consulting for plaintiffs or
11 defendants. He testified he has extensive medical training in diabetes and that roughly 10 to
12 20% of the patients he sees in his practice are diabetic. (ECF No. 45-1, p. 14-15).

13 Under Federal Rule of Evidence 702, Dr. Leo is qualified by his “knowledge, skill,
14 experience, training, or education” to offer expert testimony. Under *Daubert*, the court must
15 still assess the reliability of the proffered testimony and whether it will assist the trier of fact.
16 The Government appears to argue Dr. Leo’s opinion is not based on sufficient or reliable
17 facts and data: “Instead of responding with a treatise, medical journal, practice guide, policy,
18 hospital standards, or industry practices supporting Dr. Leo’s ‘duty to inform Dr. Barrow’
19 opinion . . .”, the Government argues Dr. Leo rests his opinion only on his own experience.
20 (ECF No. 49, p. 2). However, Dr. Leo’s opinion is, at its most basic, that there should have
21 been better communication between Dr. Sim and Dr. Barrow concerning Plaintiff’s
22 “uncontrolled diabetes” and the A1C result. One would not expect to find a treatise, medical
23 journal, or studies on when one physician should phone another with test results. When the
24 court inquired at oral argument, Plaintiff’s counsel did not direct the court to any treatise or
25 medical journal, but instead relied on language from *Gray v. Davidson*, 15 Wash.2d 257, 267
26 (1942), specifically: “It is the general rule that when a physician undertakes to treat a

1 patient, it is his duty to continue to devote his best attention to the case until either medical
2 attention is no longer needed, he is discharged by the patient, or he has given the patient
3 reasonable notice of his intention to cease to treat the patient, so that another physician may
4 be obtained.”

5 The Government rests its argument in part on a recent case from this District:
6 *Wright v. United States*, 2:15-CV-0305-TOR, 2017 WL 2590339 (E.D. Wash. 2017).
7 Therein, the plaintiff made a medical negligence claim involving the VA and argued both that
8 a nurse had inadequately communicated with the plaintiff, and that a nurse had inadequately
9 attempted to persuade a physician to order a CT scan. Judge Rice found the nursing expert’s
10 opinion lacked a sufficient “basis for the proposed standard of care or any explanation other
11 than a bald conclusion” that the nurses’ conduct fell below the standard of care. (p. 6). Judge
12 Rice cited to Washington Practice Tort Law and Practice § 16.21 (4th ed.) concerning the
13 duty of nurses: “Like pharmacists, nurses do not owe a duty to patients that would place them
14 in a position to second-guess the physician or otherwise substitute their judgment in place of
15 that provided by the physician.” (p. 8). Ultimately, the motion to exclude the expert
16 testimony was denied as moot, because even considering the expert’s opinion, the court
17 granted defendant’s summary judgment motion.

18 The *Wright* case is somewhat analogous to the case at bar as both involve claims of
19 inadequate communication between medical professionals and between medical professionals
20 and patients. The *Wright* court found no duty for a nurse to second-guess physicians. Here,
21 Dr. Leo, who admits he is not qualified to opine as to the standard of care for orthopedic
22 surgeons, argues Dr. Sim, a primary care physician, should have intervened with the
23 orthopedic surgeon, Dr. Barrow, and told him how to proceed, or not to proceed, with a
24 surgical procedure.

25 Dr. Leo’s opinion is essentially the A1C test result was cause for concern, and Dr. Sim
26 should have communicated that concern to Dr. Barrow and Plaintiff. Dr. Leo contends the

1 elevated A1C result posed an increased risk of post-surgical infection. Dr. Leo filed a Second
2 Declaration (ECF No. 38) stating the risk of infection in a patient with well controlled
3 diabetes was 1.7%, and with poor diabetes control (like Plaintiff) it was 6.8%. Dr. Leo thus
4 contends there was a four-fold increase in risk of infection. In *Daubert v. Merrell Dow*
5 (*Daubert II*), 43 F.3d 1311 (9th Cir. 1995), after the case was remanded from the Supreme
6 Court, the Ninth Circuit held there must be at least a two-fold increase in the relative risk for
7 their to be legal causation. The court stated: “In terms of statistical proof, this means that
8 plaintiffs must establish not just that their mothers’ ingestion of Bendectin increased
9 somewhat the likelihood of birth defects, but that it more than doubled it—only then can it be
10 said that Bendectin is more likely than not the source of their injury.” *Id.* at 1320. Here, Dr.
11 Leo claims the relative risk posed by the elevated A1C was four. The Government’s expert,
12 Dr. Kraemer, appears to agree there is some support in the medical literature for this
13 calculation, but that even if accepted, an increase from 1.7% to 6.8% “does not even come
14 close to approaching an incidence of infection that is more likely than not.” (ECF No. 29-2,
15 p. 145 of 188).

16 The Government’s Motion to Exclude (ECF No. 43) first challenged three opinions of
17 Dr. Leo: “(1) the standard of care required Dr. Sim to perform an unrequested preoperative
18 evaluation; (2) a preoperative A1C of 9.6 required cancellation of the surgery, and (3) Mr.
19 Brotherton’s preoperative A1C caused his infection.” (ECF No. 43, p. 2). However, the
20 Motion concludes by seeming to request exclusion of all Dr. Leo’s opinions, stating, “Dr.
21 Leo’s opinions are unreliable and inadmissible.” (ECF No. 43, p. 10). The court does not
22 view Dr. Leo’s Rule 26 report as opining Dr. Sim was required to perform an unrequested
23 evaluation. Dr. Leo’s deposition testimony would not support that conclusion. Nor does Dr.
24 Leo appear to opine an A1C of 9.6 requires cancellation of surgery in all circumstances.
25 Rather, he admits “there is no specific evidence-based target for hemoglobin A1C
26 recommended prior to surgery.” (ECF No. 20-1, p. 7). His opinion is it depends on whether

1 the surgery is elective or emergent, and his opinion appears to be Brotherton's surgery should
2 have been postponed until he was medically optimized. As to causation, Dr. Leo opines of
3 the four-fold increase in risk of infection, as discussed *supra*. The Government's request to
4 strike the opinions of Dr. Leo is **DENIED**.

5 Dr. Coleman has filed a one-page report (ECF No. 39-1), and it is improper rebuttal.
6 It is not "intended solely to contradict or rebut evidence on the same subject matter identified
7 by another party". Fed.R.Civ.P. 26(a)(2)(D)(ii). Dr. Coleman's report does not purport to
8 rebut the opinions of the Government's experts. Rather, Dr. Coleman's report appears to be
9 an attempt to bolster Dr. Leo's report and is in such respect cumulative. *See Titus v.*
10 *Progressive Casualty Ins. Co.*, 2011 WL 13233430 (D. Ariz. 2011)(excluding improper
11 rebuttal expert which the court viewed as not rebuttal but an attempt to bolster prior witnesses
12 or select a "better" expert). Dr. Coleman states: "The opinions Dr. James Leo expresses on
13 the standard of care for a primary care physician are the standard of care in Washington."
14 (*Id.*). He then repeats portions of Dr. Leo's opinion, states agreement with those opinions,
15 and concludes the "opinions by Dr. Leo reflect the standard of care for a reasonably prudent
16 primary care physician in the State of Washington." (*Id.*).

17 To the extent Dr. Coleman was used to rebut the implicit contention the California and
18 Washington standards of care are not the same, such testimony is permissible rebuttal: Dr.
19 Coleman states: "There is no difference in the standard of care in Washington compared to
20 California or nationally." (ECF No. 39-1). However, it does not appear the Government
21 presses the contention Dr. Leo is unqualified to testify on Washington standard of care
22 because he practices in California. Although Dr. Coleman's brief report does appear to be
23 improper rebuttal testimony and largely cumulative, the court in the exercise of its discretion
24 and for the purpose of this motion, **DENIES** the request to strike Dr. Coleman's report.

25 Returning to Plaintiff's medical negligence claim, and the Government's Motion
26 for Summary Judgment, the Washington Supreme Court recently stated, in *Reyes v.*

1 *Yakima Health District*, 419 P.3d 819 (Slip Op. June 21, 2018): “In a medical
2 malpractice case, plaintiffs must show that the health care provider failed to exercise that
3 degree of care, skill, and learning expected of a reasonably prudent health care provider at that
4 time in the profession or class to which he or she belongs, in the state of Washington, acting
5 in the same or similar circumstances.” (Slip Op. at p. 5 citing RCW 7.70.040(1)). In *Reyes*,
6 the Supreme Court affirmed the lower court’s grant of summary judgment for the defendants
7 and addressed whether plaintiff’s expert had created a genuine issue of material fact. The
8 Court stated: “In the context of medical malpractice, this requires an expert to say what a
9 reasonable doctor would or would not have done, that the defendants failed to act in that
10 manner, and that this failure caused the injuries. The expert may not merely allege that the
11 defendants were negligent and must instead establish the applicable standard and how the
12 defendant acted negligently by breaching that standard. Furthermore, the expert must link her
13 conclusions to a factual basis.” (Slip Op. at 6) (internal quotations and citations omitted).
14 Brotherton has offered expert testimony in support of his claims, and Dr. Leo contends Dr.
15 Sim failed to meet the standard of care.

16 Dr. Leo contends there was inadequate communication between Dr. Sim and
17 Dr. Barrow and between Dr. Sim and Plaintiff. Dr. Leo submitted an affidavit with his
18 opinion on standard of care (ECF No. 9-1), provided a Rule 26 Report (ECF No. 20-1),
19 and gave deposition testimony. (ECF No. 45-1). Dr. Leo, testified at deposition: “the
20 significant part of this case has to do with the failure of communication.” (ECF No. 45-1,
21 p. 48).

22 Dr. Leo’s Rule 26 Report sets forth six ways in which he contends Dr. Sim failed to
23 meet the standard of care (ECF No. 20-1, p. 6):

24 1. Failing to recognize the poor diabetes control represented by the preoperative
25 hemoglobin A1C of 9.6 obtained on January 13, 2014 represented a markedly increased and
26 modifiable risk of poor surgical wound healing and infection;

1 2. Failing to contract Dr. Barrow to determine whether the surgery was elective or
2 emergent;

3 3. Failing to ensure Dr. Barrow was aware of uncontrolled nature of Mr. Brotherton's
4 diabetes;

5 4. Failing to notify Dr. Barrow that Plaintiff was not medically stable to proceed with
6 surgery;

7 5. Failing to specifically inform Brotherton that his uncontrolled diabetes greatly
8 increased the likelihood of his developing postoperative wound complications; and

9 6. Failing to fulfill his duty as a PCP in acting to minimize his patient's risks for
10 complications, regardless of Dr. Sim's feelings about his patient's non-compliance, "including
11 not abdicating his duty to provide preoperative medical clearance or non-clearance for the
12 planned surgery." (ECF No. 20-1, p. 6).

13 Dr. Leo contends the standard of care requires a physician to recognize the impact
14 of poorly controlled diabetes on the post-operative risks of infection and poor wound healing.
15 (ECF No. 9-1, ¶ 5-6; ECF No. 20-1, p. 6). Dr. Leo contends Dr. Sim did not fully understand
16 the relationship between diabetes and poor wound healing. The record is not clear Dr. Sim
17 failed to recognize such risk, and Dr. Leo himself testified it is a generally known medical
18 fact: "It is well known that uncontrolled hyperglycemia impairs white blood cell function and
19 raises the risk of infection." (ECF No. 45-1, p. 37). Further, Dr. Sim's specific amount of
20 knowledge concerning the issue and the extent to which he communicated it to Plaintiff, did
21 not cause Plaintiff's injury (the amputation). Plaintiff had been living with diabetes since
22 1996, had been on insulin in 2003, and testified he was told diabetes "could cause severe
23 things up and to blindness, wounds not healing very well, loss of limb, death." (ECF No. 29,
24 ¶ 57-58). Further, Dr. Barrow was aware Plaintiff was diabetic, and was aware of slow
25 wound healing, as he monitored the slow healing ulcer on Plaintiff's left foot for several
26 months before performing the surgery on the right ankle.

1 Dr. Leo further opines it would be a violation of the standard of care for a primary care
2 physician in the state of Washington, who is aware of a patient's A1C of 9.6 to approve the
3 patient for an elective ankle surgery. (ECF No. 9-1, ¶ 7). Stated somewhat differently, in the
4 Rule 26 Report, Dr. Leo states Dr. Sim should have notified Dr. Barrow that Plaintiff's
5 diabetes was uncontrolled and Plaintiff was not medically stable to proceed with surgery.
6 (ECF No. 20-1, p. 6). Dr. Sim did not "approve" the surgery because no pre-surgical medical
7 clearance was requested by Dr. Barrow. Dr. Leo testified it is the general practice for a
8 surgeon to request medical clearance if he deems it necessary from a primary care physician.
9 (ECF No. 45-1, p. 69). Dr. Leo testified that in his experience, medical clearance would be
10 requested a month before the surgery, and Dr. Leo would either schedule a specific pre-
11 operative medical clearance office visit, or if the patient recently had an annual exam, clear
12 the patient without further evaluation. (*Id.* at p. 71-72).

13 Dr. Barrow did not request a pre-surgical clearance of Plaintiff. Rather, Dr. Barrow
14 requested some lab tests, and those tests were performed. Concerning Dr. Leo's opinion that
15 Dr. Sim should have intervened to stop the surgery because of the A1C test result, it is
16 undisputed the test result was sent to Dr. Barrow. (ECF No. 29, ¶ 39). Dr. Barrow testified
17 he also ordered a blood glucose test the morning of the surgery, and the result of that test was
18 more important to him than an A1C score. Additionally, Dr. Leo admits there is not a clear
19 medical consensus on what A1C score would make surgery contraindicated. He states in his
20 Rule 26 Report "there is no specific evidence-based target for hemoglobin A1C recommended
21 prior to surgery," but that studies have shown an increased risk of infection. (ECF No. 20-1,
22 p. 7).

23 All of these criticisms by Dr. Leo essentially amount to a contention that Dr. Sim
24 should have been more concerned with the A1C result, communicated his concern to Dr.
25 Barrow and Plaintiff, and recommended the surgery not go forward. Dr. Leo believes the
26 surgery should have been postponed until Plaintiff was medically optimized. The

1 Government contends Plaintiff cannot show the surgery would not have proceeded. However,
2 Dr. Barrow testified he had not reviewed the A1C prior to the surgery, and had he seen it, he
3 “possibly” would have still performed the surgery because he does not view the A1C as a
4 contraindication to surgery. (ECF No. 29-2, p. 21-22 of 188).

5 Dr. Leo is not a surgeon. He testified, “I hesitate to opine as to the standard of
6 care of an orthopedic surgeon.” (ECF No. 45-1, p. 42). He further testified: “The
7 question as to what Dr. Barrow’s duty was in obtaining a medical clearance for this
8 patient with a number of different medical problems aside from this Type 2 diabetes,
9 is one that I will defer to the orthopedic expert in this case.” (*Id.* at 42-43). Thus Dr. Leo does
10 not opine Dr. Barrow should have sought pre-surgical medical clearance, and Dr. Barrow did
11 not seek Dr. Sim’s opinion as to medical clearance. However, Dr. Leo claims Dr. Sim had
12 a “duty as the primary care physician to say this patient is not medically cleared or optimized
13 to proceed with surgery and to contact Dr. Barrow and let him know.” (*Id.* at 41).

14 Viewing the facts in the light most favorable to Plaintiff for the purposes of this
15 summary judgment motion, and considering the opinions of Plaintiff’s expert, Dr. Leo, the
16 court finds the Government has not established it is entitled to judgment as a matter of law
17 on the medical negligence claim.

18 **IV. Conclusion**

19 The Complaint in this matter asserts two claims: 1) Failure to Secure Informed
20 Consent; and 2) Medical Negligence. The court finds as a matter of law Dr. Sim had no duty
21 to secure informed consent for the surgical procedure performed by Dr. Barrow. Dr. Sim did
22 not plan or participate in the surgery. Plaintiff saw Dr. Barrow on multiple occasions prior
23 to the surgery. Plaintiff’s informed consent claim was not supported by expert testimony.

24 Plaintiff’s claim of medical negligence was supported by the testimony and report of
25 Dr. Leo, and additionally by the conclusory opinion of Dr. Coleman. The Government’s
26 position is supported by its three experts: Dr. Oakley, Dr. Kraemer, and Dr. Ledgerwood. The

1 medical negligence claim thus presents a material dispute between expert witnesses
2 concerning the standard of care, whether it was breached, and causation. Given this dispute,
3 the court denies summary judgment on the medical negligence claim.

4 **IT IS HEREBY ORDERED:**

5 1. The Government's Motion to Exclude (ECF No. 43) is **DENIED**.

6 2. The Government's Motion for Summary Judgment (ECF No. 28) is **DENIED IN**
7 **PART AND GRANTED IN PART**. The Government is granted summary judgment on
8 Plaintiff's claim that Dr. Sim or VA medical personnel failed to secure informed consent.
9 The Government's Motion is denied as to the medical negligence claim.

10 **IT IS SO ORDERED.** The Clerk is hereby directed to enter this Order and furnish
11 copies to counsel.

12 **DATED** this 7th day of August, 2018.

13
14 s/ Justin L. Quackenbush
15 JUSTIN L. QUACKENBUSH
16 SENIOR UNITED STATES DISTRICT JUDGE
17
18
19
20
21
22
23
24
25
26